STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445228	A. BUILDING _____ B. WING _____	C 05/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF GREENEVILLE	725 CRUM STREET GREENEVILLE, TN 37743

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to accommodate the need for placement of the call light of two (#1, #3) of five residents reviewed. The findings included: Resident #1 was admitted to the facility on August 4, 2002, with diagnoses including Asthma, Paranoid Personality Disorder, Stress Urinary Incontinence, Seizure Disorder, Hypertension and Atrial Fibrillation. Medical record review of the Minimum Data Set (MDS) dated April 10, 2011, revealed the resident had intact decision-making skills; required extensive assistance with bed mobility, hygiene and bathing; was totally dependent on staff for transfers; had impairment in range of motion of upper and lower extremities on one side; used a wheelchair for mobility; and was always incontinent of urine and had frequent incontinence of bowel. Medical record review of the physician's recapitulation orders dated May 1-31, 2011, revealed, "Detrol LA (urinary incontinence) 4 mg	F 246	**F246** CORRECTIVE ACTION: Call lights were placed within reach of Resident #1 and #3 immediately. All personnel were immediately in-serviced on Life Care Center of Greeneville's policy and procedure for call light placement on 5/4/11 by the staff development coordinator. RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents were assessed to assure that call lights were within reach on 5/4/11 by the unit managers. No other residents were found to be affected SYSTEMATIC CHANGES: All facility personnel were in-serviced on 5/4/11 and on 5/12/11on the appropriate procedure and expectations for assuring call lights are within residents' reach by the staff development coordinator. MONITORING: Beginning 5/5/11, unit managers and/or charge nurses will make daily rounds on first and second shifts to assure compliance. Rounds will continue for three months and cease on 9/1/11. Beginning 5/5/11, the director of nursing, assistant director of nursing, and/or weekend manager will assure compliance by making daily rounds on first and second shifts. This will continue for three months and cease on 9/1/11.	**5/20//11**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer C Solomon, MA, ED — TITLE: Executive Director — (X6) DATE: 5/19/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

MAY 23 2011

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LIFE CARE CENTER OF GREENEVILLE	725 CRUM STREET GREENEVILLE, TN 37743

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F 246	Continued From page 1 (milligram) capsule...Take 1 cap (capsule) by mouth every day...Incontinence..." and "Furosemide (diruretic) 20 mg...1 tab (tablet) by mouth every day..." Medical record review of the care plan updated April 20, 2011, revealed, "...Multiple falls, hx (history) of rib & (and) pelvic fxs (fractures)...Place items frequently used by resident within easy reach, to avoid resident reaching for items..." Observation on May 4, 2011, at 9:30 a.m., revealed the resident sitting in a wheelchair near the foot of the bed. Observation revealed the call light was not in sight. Interview on May 4, 2011, at 9:30 a.m., revealed the resident stated, "I need to go to the bathroom." Continued interview with the resident confirmed the call light was not in sight. Interview in the resident's room on May 4, 2011, at 9:35 a.m., with Certified Nursing Assistant (CNA) #1 confirmed the call light was covered by the comforter; was not in sight; and was not in reach of the resident. Resident #3 was admitted to the facility on September 12, 2008, with diagnoses including C5 (fifth cervical vertebra) partial Quadriplegia secondary to C5 Myelopathy, Abdominal Aortic Aneurysm, Venous Insufficiency, Chronic Obstructive Pulmonary Disease, Parkinson's Disease, Paranoid Schizophrenia, Anemia and Neurogenic Bladder. Medical record review of the MDS dated April 24, 2011, revealed the resident had moderately impaired	F 246	All findings from the rounds will be turned into the facility's executive director and./or director of nursing. The ED/DON will report findings monthly to the Quality Assurance/Performance Improvement Committee. This information will be reviewed beginning 6/21/11 and cease on 9/20/11, unless there is need for further observation.	5/20//11

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F 246	Continued From page 2 decision-making skills; was totally dependent on staff for bed mobility, eating, hygiene and bathing; required extensive assistance with transfers, ambulation, and dressing; was occasionally incontinent of bowel and had an indwelling urinary catheter. Review of a hospital history and physical dated March 25, 2011, revealed, "...history of cervical spine disease of...discs since 2007...head chronically turned to the right side...no movement of upper extremities...hands are pronated anteriorly...muscle wasting in the forearms of both extremities..." Medical record review of the current care plan revealed, "...Teach resident to call for assistance before transferring or ambulating...Adapt the environment to increase safety and independence...Place items that resident uses frequently within sight and easy reach..." Observation on May 4, 2011, at 10:00 a.m., revealed the resident lying in bed with severely deformed positioning of the arms and head. Observation revealed the resident was not able to raise the arms, and the head was positioned to the right, touching the right shoulder. Observation revealed the resident was slightly positioned on the right side facing the window. Observation revealed a touch-pad call light was on the opposite side of the bed, draped over a wooden board on the night stand. Observation revealed the call light was not within sight or reach of the resident. Interview on May 4, 2011, at 10:00 a.m., revealed the resident was alert and oriented and asked for	F 246		

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F 246	Continued From page 3 a drink from the refrigerator in the room. Continued interview confirmed the touch-pad call light was not in sight and was not within reach of the resident. Observation and interview in the resident's room on May 4, 2011, at 10:10 a.m., with CNA #2 and Licensed Practical Nurse (LPN) #1 confirmed the call light was not in sight or in reach of the resident. Continued interview with the LPN confirmed the resident was able to activate the call light if placed under the hand.	F 246		
F 327 SS=D	C/O #27620 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure water was within reach of one (#2) of five residents reviewed. The findings included: Resident #2 was admitted to the facility on April 14, 2011, with diagnoses including Anemia, Cerebral Vascular Accident (Stroke), Chronic Kidney Disease Stage 3, Anxiety, Hypothyroidism, Hypertension and Venous Thrombosis. Medical record review of the Minimum Data Set dated (MDS) April 24, 2011,	F 327	**F327** CORRECTIVE ACTION: Resident #2's water pitcher was immediately placed within her reach. All personnel involved were immediately in-serviced on providing proper hydration and assuring water pitchers are within the resident's reach on 5/4/11 by the staff development coordinator.. RESIDENTS WITH POTENTIAL TO BE AFFECTED: All residents were assessed to assure water pitchers were within reach of each resident on 5/4/11 by the unit managers. No other residents were found to be affected. SYSTEMIC CHANGES: All facility personnel were in-serviced on 5/4/11 and 5/12/11 on assuring water pitchers are within residents' reach and on proper hydration by the staff development coordinator.	**5/20//11**

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F 327	Continued From page 4 revealed the resident had no impairment of decision-making skills; was totally dependent on staff for bed mobility and transfers; required extensive assistance with dressing, hygiene and bathing; and was incontinent of urine and bowel. Medical record review of the care plan dated February 23, 2011, revealed, "...Increase fluid consumption during day hours and limit fluid consumption in evening hours...Potential for fluid volume deficit...Report any negative fluid trends to physician...Monitor...for signs for dehydration...Independent with fluid intake...Keep filled water pitcher @ (at) bedside & (and) within easy reach..." Observation on May 4, 2011, at 9:50 a.m., revealed the resident lying in bed, alert and oriented. Observation revealed the resident's water pitcher was on an over-bed table approximately three feet from the resident's reach. Interview with the resident on May 4, 2011, at 9:50 a.m., confirmed the water pitcher was not in reach of the resident. Continued interview revealed when the resident wanted a drink of water and put the call light on, "It takes them a while to answer. I wish they'd put it closer (water)." Observation and interview in the resident's room on May 4, 2011, at 9:55 a.m., with Certified Nursing Assistant (CNA) #1 confirmed the water pitcher was not within reach of the resident. C/O #27620	F 327	MONITORING; Beginning 5/5/11, unit managers and/or charge nurses will make daily rounds on first and second shifts to assure compliance. Rounds will continue for three months and cease on 9/1/11. Beginning 5/5/11, the director of nursing, assistant director of nursing, and/or weekend manager will assure compliance by making daily rounds on first and second shifts. This will continue for three months and cease on 9/1/11. All findings from the rounds will be turned into the facility's executive director and./or director of nursing. The ED/DON will report findings monthly to the Quality Assurance/Performance Improvement Committee. This information will be reviewed beginning 6/21/11 and cease on 9/20/11, unless there is need for further observation	5/20//11

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